



Personal continuity versus specialisation of care approaches in mental healthcare: experiences of patients and clinicians—results of the qualitative study in five European countries

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Received: 27 February 2019 / Accepted: 20 August 2019
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Abstract

Background The current debate on organisation of the mental health care raises a question whether to prioritise specialisation of clinical teams or personal continuity of care. The article explores the experiences of patients and clinicians regarding specialisation (SC) and personal continuity (PCC) of care in five European countries.

Methods Data were obtained via in-depth, semi-structured interviews with patients ($N=188$) suffering from mental disorders (F20–49) and with clinicians ($N=63$). A maximum variation sampling was applied to assume representation of patients and of clinicians with different characteristics. The qualitative data from each country were transcribed verbatim, coded and analysed through a thematic analysis method.

Results Many positive experiences of patients and clinicians with the PCC approach relate to the high quality of therapeutic relationship and the smooth transition between hospital and community care. Many positive experiences of patients and clinicians with the SC approach relate to concepts of autonomy and choice and the higher adequacy of diagnosis and treatment. Clinicians stressed system aspects of providing mental health care: more effective management structure and higher professionalization of care within SC approach and the lower risk of disengagement from treatment and reduced need for coercion, restraint, forced medication or involuntary admission within PCC.

Conclusions Neither the PCC, nor the SC approach meets the needs and expectations of all patients (and clinicians). Therefore, future reforms of mental health services should offer a free choice of either approach, considering that there is no evidence of differences in patient outcomes between PCC and SC approaches.

Keywords Mental health care organisation · Functional system · Integrated system

Introduction

Across Europe, health systems have become fragmented because of medical specialisation, high levels of decentralisation, increased professionalization, novel financing schemes

and diversity in the alternatives for service provision [1]. The current debate on the organisation of the mental health care system raises a question whether to prioritise specialisation of clinical teams by separation of inpatient and outpatient care or personal continuity of care approach where the same primary clinician is responsible for an individual patient within hospital and community services [2–6]. Both approaches have their own stakeholders and both prevail in different countries as a result of mental health care reforms having significant consequences in each country in terms of allocation of resources and service organisation [5, 7–9].

The literature shows that the specialisation of care approach (SC) is expected to simplify the practical organization of services, support quick clinical decision-making, enable clinical teams and clinicians to focus on only one setting, and foster an expertise in setting specific aspects

All authors declare that the submitted work has not been published before (neither in English nor in any other language) and that the work is not under consideration for publication elsewhere.

Electronic supplementary material The online version of this article (<https://doi.org/10.1007/s00127-019-01757-z>) contains supplementary material, which is available to authorized users.

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of treatment [2, 4, 10]. On the one hand, proponents of this approach claim that the increasing specialisation of psychiatric services represents a progress in our understanding of mental health problems [9]. On the other hand, the personal continuity of care approach (PCC) is expected to facilitate smooth transition of patients from one setting to another, to support long-lasting therapeutic relationships, and to simplify clinical communication as patients and clinicians are familiar with each other across the care settings [2, 5, 6, 8].

The mental health reforms in different countries were not evidence based as the available research has brought inconclusive results and suffered from serious methodological shortcomings (small sample size, local settings, limited range of outcomes, comparison of newly implemented approaches with traditional ones) [2, 11]. Moreover, a qualitative exploration of those issues is lacking. Mental health care approaches are complex; as much as it is important to assess their clinical outcomes and costs, focusing exclusively on such aspects, would overlook the personal experiences and preferences of patients and clinicians, which are so far under-researched.

We are addressing this research gap by presenting qualitative data drawing upon the experiences of patients and clinicians in five European countries (Belgium, Germany, Italy, Poland and UK) who have received or provided care within at least one of the two care approaches—SC and PCC. The positive and negative experiences of frontline providers and recipients of care are important contributions regarding policy decision-making, they may also shed light on the mechanisms by which each of the system can be clinically effective or more responsive to the specific expectations and needs.

Methods

Data collection

The qualitative data set presented here is a part of the recent COFI study (Full title: Comparing policy, framework, structure, effectiveness and cost-effectiveness of functional and integrated systems of mental health care) comparing specialisation and personal continuity care in five European countries (Belgium, Germany, Italy, Poland and the UK), where those approaches are the standard way of providing mental health care [2]. The COFI project was a prospective, multi-country natural experiment conducted in 57 hospitals involving over seven thousands of patients using specialisation and personal continuity of care. Its quantitative results showed no difference between specialisation and personal continuity care approaches in rehospitalisation rates, number of inpatient bed days, untoward events and social functioning in the total sample [12]. Therefore, a complementary qualitative approach was crucial to increase our general understanding of both approaches in mental health care.

Data were obtained via in-depth, semi-structured interviews with patients and clinicians regarding personal experiences of providing or receiving care within SC and PCC approaches. Trained interviewers were following the unified study protocol and interviews' guidelines developed in a process involving all partners and including several revision rounds and pilot interviews in each country ([2]—a detailed protocol of the COFI study).

To assure diversity of the sample (maximum variation sampling), researchers recruited similar numbers of patients treated with SC versus PCC approaches, who had varying personal characteristics (gender, age, treatment history) and clinical diagnosis (ICD-10) of psychotic disorders (F20–29), affective disorders (F30–39) or anxiety/somatisation disorders (F40–49). Accordingly, the sample of clinicians had different characteristics regarding gender, age, the care approach adopted by the service they work within (PCC or SC) and their profession: psychiatrists, psychologists, nurses, social workers. Clinicians were recruited from the hospitals or community mental health services participating in the project. All participants were offered vouchers (25 €) to compensate for their time and commitment.

Data analysis

Data from semi-structured interviews with patients and clinicians were audiotaped and transcribed verbatim, ensuring the removal of any identifying information to maintain anonymity and confidentiality. Study centres in each country generated a list of initial codes based on a line-by-line analysis of translated pilot interviews using CAQDA (computer-assisted qualitative data analysis). The meaning of each initial code was discussed between all coders. As a result, the initial codes were grouped and summarised into unified coding books for patients (266 codes) and for clinicians (245 codes). Additionally, the consistency of coding across all centres was assessed and discrepancies were discussed till the consistency had reached a satisfactory level and the coders from each study centre coded the selected part of the transcript applying a core set of identical codes.

In the next step, all partner countries coded a priori all transcripts (CAQDA) applying the separate codebooks for patients and clinicians and using line-by-line analysis (Atlas.ti) [13, 14]. Equal attention was given to each data item and extracts of data were coded inclusively not to lose the context. If new codes emerged, they were adopted if approved by all partners.

Each partner country produced the coding report translated into English which comprised of basic information about the national sample, list of all codes with data extracts, which captured the essence of the particular code without unnecessary complexity, and research memos regarding the coding procedure and data analysis.

In the next step, coding reports from each country were analysed through a thematic analysis method—some codes were combined to form an overarching theme, others were refined, separated, or discarded [14, 15]. To obtain meaningful themes in relation to the comparison of both care approaches, positive and negative personal experiences of patients and clinicians were organised and grouped using a realist, semantic approach. To progress from description to data interpretation, and to theorise about meaning and implications of the data collected, patient and clinician experiences were compared and interpreted as advantages and disadvantages of PCC and SC approaches.

Sample description

Patient sample

We interviewed a total of 188 patients, 60% female and 40% male. Thirty-nine percent of the patients had experience of receiving personal continuity of care, 53% specialisation of care, while 8% experienced both approaches during 1-year follow-up. Full details of sample characteristics are shown in Table 1.

Clinician sample

In all countries, psychiatrists are the main clinicians and decision-makers regarding patients' treatment; therefore, making up 60% of the sample. Remaining interviews were conducted with other staff members including psychologists, psychiatric nurses and social workers. Detailed sample characteristics are presented in Table 2.

Results

Homogeneity of experiences

An initial assumption was that socio-cultural and historical differences between the five countries participating in the COFI study would be reflected by the qualitative data. However, we have found that the opposite is true—the analysis shows a high level of homogeneity in the data collected across partner countries. Patients and clinicians in all five participating countries shared very similar experiences and the understanding of features characteristic to both approaches. Therefore, the data from all five countries are presented together.

Moreover, clinicians and patients showed high level of consistency when describing their positive and negative experiences with both personal continuity and specialisation of care. To illustrate the homogeneity of the data, we are presenting quotations from clinicians (C) and patients (P) in the tables. Clinician quotations in the text are marked by country (BE, IT, GE, PL, UK), type of care (PCC/SC), and profession (differentiated by id number) and patients' quotations in the text are marked by country (BE, IT, GE, PL, UK), type of care (PCC/SC), gender (F/M), age, and type of disorder.

Positive experiences with PCC

Patients

We have identified a number of positive experiences related to different features of personal continuity of care, which are perceived by patients as advantages. Some of them relate

Table 1 Patient sample characteristics

		BE	GE	IT	PL	UK	Total
No. of interviews		40	39	28	40	41	188
Time of the interview	Average (in min.)	66	37	30	48	48	46
Gender	Male, <i>n</i> (%)	18 (45%)	14 (36%)	8 (29%)	17 (42%)	19 (46%)	76 (40%)
Age (in years)	Average	43	41	44	43	48	44
	Minimum	21	21	20	23	22	20
	Maximum	66	63	64	63	64	66
Approach in care (no. of cases)	PCC	21	8	12	12	21	74
	SC	19	27	16	18	19	99
	BT (both)	0	4	0	10	1	15
ICD-10 diagnosis (no. of cases)	F20–29	12	8	8	10	14	52
	F30–39	19	23	10	17	21	90
	F40–49	9	8	10	13	6	46

Belgium (BE), Germany (GE), Italy (IT), Poland (PL) and the United Kingdom

Table 2 Clinician sample characteristics

		BE	GE	IT	PL	UK	Total
No. of interviews		13	10	12	13	15	63
Time of the interview	Average (in min.)	67	36	31	41	50	45
Gender	Male, <i>n</i> (%)	6 (46%)	5 (50%)	6 (50%)	5 (38%)	11 (73%)	33 (52%)
Approach in care (no. of cases)	PCC	0	0	5	5	8	18
	SC	0	6	7	6	6	25
	BT (both)	13	4	0	2	1	20
profession (no. of cases)	Psychiatrist	6	5	8	8	11	38
	Psychologist	1	3	0	3	1	8
	Social worker	5	2	0	2	1	10
	Nurse	1	0	2	0	2	5
	Trainee (psychiatrist)	0	0	2	0	0	2
Years of experience	Average	15	10	18	19	19	16

Belgium, Germany, Italy, Poland and the United Kingdom

to the quality of the clinician–patient relationship: patients felt their problems were addressed in a more holistic way, there was less confusion, stress and frustration during the consultation, and in general the therapeutic alliance has been stronger—built over longer period of time and characterised by trust and sense of security, even in a crisis situation. Moreover, patients believed that the PCC approach leads to shorter hospital stays and smoother transitions between hospital and community care. Examples of patients' argumentations are presented in Table 3, next to the similar clinicians' argumentations.

Clinicians

Patients' accounts have been confirmed by clinicians who shared their opinions of the quality of the therapeutic alliance in PCC, holistic approach to patients' problems and sense of security in crisis situation. Clinicians also believe that PCC allows to avoid confusion about treatment recommendations and frustration of repeating personal story (Table 3). They have also discussed additional organisational advantages of PCC, besides shorter hospital stays and smooth transitions between the settings. Those advantages of PCC are listed below with quotations which illustrate the arguments raised by clinicians:

- higher adherence to treatment;

C: It promotes the adherence to treatment, promotes the understanding from the patients about what we are doing for them, promotes the compliance... also from the family... the compliance to the care project (IT-PCC: psychiatrist).

- reduced need for coercion, restraint, forced medication or involuntary admission;

C: The patient was very unwell, he had bipolar, he was very manic and very vulnerable—needed to come to hospital—but because he had a really good relationship with the consultant he agreed to come to hospital voluntarily. If that had been a different consultant who did not know that patient, the patient would have had to been sectioned (UK-PCC: nurse).

- lower risk for disengagement from treatment;

C: Further treatment by the familiar person, familiar personnel means significantly fewer disengagements and also not so much information is lost (GE-BT: psychologist/psychiatrist).

- more satisfaction for clinician—seeing patient's condition improved after discharge;

C: It's nice to see people over a long period of time. (...) You've got that knowledge, what works and what does not work, and you've seen them ill and well. Just to see ill people all the time, and as soon as someone gets well they disappear, and another ill person comes in... in my experience people burn out, especially inpatient consultants (UK-PC: psychiatrist).

- better communication between different clinicians/services.

C: (...) relationships between staff are just as important. They know you so you can talk (UK-PC: psychiatrist).

Table 3 Positive experiences of patients and clinicians with personal continuity care approach

Positive experiences with PCC	
Clinicians	Patients
Stronger therapeutic alliance	
C: <i>The relation with the patient is very profound... you really have the feeling that you are taking a piece of the road together with the patient</i> (IT-PCC: psychiatrist)	P: <i>Patients like me feel better with a clinician who they know and who knows them. The relationship doesn't have to be built during every new session. Then it's easier to talk because the matters covered are rather sensitive and some walls have to be broken down (...). For me it's better for both patient and clinician. It is possible to focus on current issues</i> (PL-PCC: F58/affective disorder)
More holistic approach to patients' problems	
C: <i>With a more holistic approach, the clinician sees the whole picture. For example, we have a patient who (...) lost his home (...) his mother had also suffered from schizophrenia and had committed suicide. (...) the father abused alcohol and there was a lot of violence at home. (...) We went through it together and it brought us together. Had he come to us from the best clinician with some laconic report and he'd have to describe it all over again, he would not have handled it</i> (PL-PCC: psychiatrist)	P: <i>When my wife had cancer, I was visiting her [my clinician] all the time and she simply lead me through and helped me out with medications so I did not fall apart. She guided me after my wife's death as well. (...) Having a good trusted clinician who has empathy and does not treat me like a number or a patient only, but like a person</i> (PL-PCC: M56/anxiety disorder)
Less confusion about medications and treatment recommendations	
C: <i>I think it was better for patients to have a consistent relationship with a psychiatrist. (...) personal continuity did avoid some of the problems of patients coming across consultants with completely different views... [which we have now]</i> (UK-SC: psychiatrist)	P: <i>The clinician who conducted my treatment in hospital and following my discharge is able to compare. I think he got to know me over those two weeks at the hospital when he took care of me and can relate that to various levels of my mood and emotional state</i> (PL-BT: F25/anxiety disorder)
No stress and frustration of having to repeat personal story	
C: <i>There is less anxiety and the patient doesn't have to get stressed about coming in and telling the clinician the whole story</i> (PL-PCC: social worker)	P: <i>If I had to get a new psychiatrist now and explain everything (...). It would take me 4 sessions, and we could only start work at the end of 4 sessions, which is actually 4 months later, so I would not get better for 4 months. By the time everything settles down again I've lost a whole year</i> (BE-PCC: M66/psychotic disorder)
Greater sense of security in crisis situation	
C: <i>It can be calming for the patient to know that someone knows him well, knows his story and remains present. I would say it's reassuring for the patient (...) to have continuity</i> (BE-BT: psychiatrist)	P: <i>There's the familiarity and the sense of safety from seeing the same face. There's feeling like they know you when you're well so they'll possibly be more inclined to involve you in any decisions they make while you're acutely unwell, for as much as they can anyway. [Sigh]</i> (UK-PCC: F35/psychotic disorder)
Shorter hospital stays	
C: <i>We can intercept crises. I think we can see when our patients are usually a little unstable. We can mitigate it or even shorten the stays in the hospital</i> (GE-BT: psychologist)	P: <i>You're dealing with a fresh doctor every time, they've got to reopen your case and go through your history and so they started keeping me in this ward, but there's no continuity there, they don't know what medications you take, they don't know your coping strategies, nothing...</i> (UK-PCC: M58/psychotic disorder)
Smooth transition between settings	
C: <i>Personal continuity is easier—if there is a link, patients do not feel the discontinuity in the transition through settings</i> (IT-SC: psychiatrist)	P: <i>The clinician controls the whole process from the ward to the centre. He arranged all the paperwork, prepared everything and in 1 day I was discharged and no hassle. I got a definite date for a visit and information as to where I was to go. Everything was clear and did not require any additional effort or searching. And because I was very pleased with the clinician, and I also knew I was going to see the same psychologist, I had no doubts at all...</i> (PL-PCC: F58/affective disorder)

Results from Belgium, Germany, Italy, Poland and the United Kingdom

Positive experiences with SC

Patients

Some patients treat the fact of being treated by two different clinicians in two different settings as natural: they have never questioned it, as they feel that they have a good rapport with both clinicians, especially if the collaboration between inpatient and outpatient services is well established. Analysis of patients' positive experiences led to the identification of features related to specialisation of care, which can be interpreted as advantages of this approach. Patients believe they experienced more autonomy and more choice and could separate a crisis period from regular life, which was important to them. Moreover, they felt that the staff at the hospital wards was more available for them and believed that they had higher chances receiving a more accurate diagnosis and treatment. Their reasoning is presented in Table 4.

Clinicians

The experiences of clinicians with specialisation of care which are perceived as a relative advantage of that

approach over personal continuity of care are very similar to the patients' views as Table 4 shows. However, clinicians also addressed two additional features related to the organisation of care. They believe that SC approach offers a higher professionalization of care,

C: Clearly the fact that there is a team dedicated to the ward allows a specialisation of care and the best management of acute phases (IT-SC: psychiatrist).

and a more effective management structure.

C: I feel specialisation of care may make it a bit easier for the system to accommodate the different treatment options, availability of staff, just to manage that a bit better (UK-PC: nurse).

Negative experiences with PCC

Patients

We have also identified some features related to patients' experiences with personal continuity of care which constitute a relative disadvantage of the approach over specialisation of care (Table 5). Patients talked about limited possibilities to confirm the diagnosis as well as treatment

Table 4 Positive experiences of patients and clinicians with specialised care approach

Positive experiences with SC	
Clinicians	Patients
Better supports patients' autonomy	
C: <i>It's a patient who is active... (...) It's also a patient for whom we have built an outpatient structure adapted to the situation at the appropriate moment. It's a patient who cuts off, when they stop their hospitalisation</i> (BE-BT: psychiatrist)	P: <i>I saw that they trusted me [because they gave me the opportunity to go outside the ward]... They understood that I wasn't there to make trouble but rather to follow my pathway and leave as soon as possible...</i> (IT-SC: M23/affective disorder)
Different clinicians provide new, additional information or more adequate diagnosis and treatment	
C: <i>Sometimes it is really quite good, if someone different has a look at the situation, this results in more opinions. Finally, it may even result in different treatment approaches</i> (GE-SC: psychiatrist)	P: <i>More than one opinion is better and if they coincide then it is even better. That is why I see it positively, that I was treated by more than one doctor</i> (GE-SC: M34/psychotic disorder)
Patients have more choice regarding the change of the clinician	
C: <i>(...) Some patients are happy to not see me and to have another clinician, this depends on the diagnosis and on the personal relationship that they have with you</i> (IT-SC: psychiatrist)	P: <i>I have a chance to compare people, clinicians and their professionalism. And whether they are not doing any harm with their medications. That is very important</i> (PL-SC: F63/psychotic disorder)
Different clinicians across settings help to separate a crisis period from regular life	
C: <i>There are patients that for some time prefer to be away from everything, including the outpatient staff</i> (IT-SC: psychiatrist)	P: <i>It is better that the person who takes care of the severe phases sees people only in the worse [periods], and the clinician who refers to the hospital and takes on outpatient care actually has a chance to see the person in the reality of daily life</i> (PL-SC: F32/psychotic disorder)
Higher availability of staff in a hospital ward	
C: <i>I'm not splitting my time between here and the wards and sometimes here and sometimes there</i> (UK-SC: psychiatrist)	P: <i>If you have the same doctor, they'd be very busy and that it'd be a lot to take on, but as long as both doctors inside and outside the hospital know exactly what's going on, then two doctors is fine</i> (UK-SC: M24/psychotic disorder)

Results from Belgium, Germany, Italy, Poland and the United Kingdom

recommendations, and a somewhat lower availability of staff in hospital wards. Moreover, they felt that PCC approach results in having more difficulties in separating and isolating a crisis period from a regular life:

P: I think there should be an inpatient psychiatrist and an outpatient psychiatrist because the inpatient psychiatrist sees you when you're unwell... I've got a new consultant psychiatrist at the moment and I like the fact that she has met me when I'm well in the community because then she doesn't have that previous picture or judgement of me (UK-PCC: F30/affective disorder).

Clinicians

Similar features related to clinicians' experiences with the personal continuity model of care, constituting a relative disadvantage of this approach over specialisation of care, were identified (Table 5). Moreover, clinicians see the personal continuity of care approach also related to the higher workload and management difficulties.

C: That works very well, but psychiatrist have got massive caseloads. How much they know each person in detail, I'm not sure, because they've got so much they've got to deal with (UK-PCC: psychologist).

C: It takes time and commitment and often it is not possible to reconcile hospital work with community work. Sometimes it's hard to treat the same patient for years. It's sometimes so stressful to work with the same family all the time, especially when working at the hospital as well (PL-PCC: psychiatrist).

Negative experiences with SC

Patients

We have also identified a number of features related to patients' experiences with specialisation of care which constitute a relative disadvantage of that form of care in comparison with personal continuity care. Those features again relate to the quality of a therapeutic relationship [(1) low trust in unfamiliar clinicians, (2) a less holistic approach to patients' problems, (3) frustration or stress of patients having to repeat their personal story], accuracy of diagnosis and treatment (receiving confusing recommendations from different clinicians) and organisation of care [(1) lack of smooth transition between hospital and community care, (2) longer inpatient stays, (3) higher uncertainty of clinician at discharge]. As those features correspond to—as opposites—the advantages of personal continuity care approach described above (Table 3), Table 6 illustrates only selected themes.

Table 5 Negative experiences of patients and clinicians with personal continuity care approach

Negative experiences with PCC	
Clinicians	Patients
Limited possibility to confirm diagnosis and treatment with other clinicians	
C: <i>I don't see it as the ideal solution... because it is likely that having only a clinician freezes the vision of the patient which instead needs different points of view</i> (IT-PCC: psychiatrist)	P: <i>...and at one point we were all sitting there, the four of us, that were all same psychiatrist's patients in the hospital (...) and realised that we were all taking quetiapine with four completely different diagnoses. (...) So it would be good to be able to have a different opinion... I thought that might not be the best about having just seen same psychiatrist all the time</i> (UK-PCC: F23/affective disorder)
Lower availability of staff in a hospital ward	
C: <i>You are more thinly spread between, so you cannot be on both sides at one time, so you have to give part of your time to inpatient and part of your time for the outpatient</i> (UK-PCC: psychiatrist)	P: <i>They didn't have the time. It works better through external visits since there are certain windows to receive us for a half hour, forty-five minutes of discussion. But in the hospital setting, we realize that it gets botched, some people don't stop calling so we're talking about the bare minimum, about the medication, did you sleep well, how are you doing with everything, that's all</i> (BE-PCC: F32/affective disorder)

Results from Belgium, Germany, Italy, Poland and the United Kingdom

Clinicians

Clinicians had the similar perception of disadvantageous features of specialisation of care and have mentioned all features described in patient accounts (Table 6). However, they have also discussed some other important features related to clinicians' experiences with specialisation of care which constitute a relative disadvantage of that form of care in comparison with personal continuity care:

- higher risk of disengagement from treatment;
- communication problems between different clinicians and services;
- conflicts between different clinicians and services;
- less satisfaction for clinician—not seeing patient's condition improved.

The arguments of the clinicians can be illustrated by the following quotation:

C: So, the main difference is, that it's more frustrating. Because if you've got an idea you can not follow it through because you have to delegate and ask someone else to do it for you, and they need to be convinced, which is difficult if you have a dedicated and knowledgeable person who has got their own ideas, then to convince them that well, your idea is a good idea—it takes a lot of time, especially if it's controversial... I think that's the main problem; that's frustrating and it's setting people up to get more and more fights with each other; because you have to bridge all these interfaces, then they have to live with the frustration that the team that you are asking to follow-up your ideas may be not wanting to follow that up and saying look but we do not see it this way, we see it totally different. (...) misunderstandings are the norm. The more interfaces you create, the more misunderstandings we will get, and the more people that drop out in-between. (...)

Table 6 Negative experiences of patients and clinicians with specialised care approach

Negative experiences with SC	
Clinicians	Patients
Low trust in unfamiliar clinicians and frustration or stress of having to repeat personal story	
C: <i>It would definitely be good for patients if the reference person would stay the same. And I think it would be a huge advantage for the doctors if trust is established</i> (GE-SC: social worker)	P: <i>It is often very strenuous, if one has to keep on starting from the beginning and has the feeling 'I've just told someone else everything'. When I change, they naturally have no idea of what I told the other person and ask the same questions again, which I know by heart. I fell into a kind of monotony and simply answer like a gramophone record, which keeps on repeating the same thing, but omits some details, leaves out this and that to speed up the process</i> (GE-SC: F29/affective disorder)
C: <i>It's true that patients say, "are you going to send my file, are you going to explain to the people you send me to see?", because the feeling often is "I do not want to tell this whole story again"</i> (BE-BT: psychiatrist)	
Receiving confusing recommendations from different clinicians	
C: <i>I think it can be really confusing—we can disagree on medication, on diagnosis, and that means that you're disagreeing on the message you give to people about the nature of their problems and how they should address them</i> (UK-SC: psychiatrist)	P: <i>...but they've all got their own opinions, and obviously I've got my own opinion as well (...). Especially when it comes to medication... Right now, my doctor in hospital reckons I should be on the injection and my doctor in the community is not sure. So it's been down to me to decide</i> (UK-SC: M31/affective disorder)
Lack of smooth transition between hospital and community care	
C: <i>I have such a concrete case in mind that I can not get out of my head. It was a woman patient whom I had transferred to the outpatient appointment and further treatment. (...) The patient did not keep her psychiatric appointment and again slipped into the psychosis. (...) My hands are tied, because I am no longer treating the patient</i> (GE-SC: psychologist)	P: <i>There is a smooth transition missing, so in general there is a lack of connection between ward and outpatient clinic, where in the beginning someone is helping to manage daily issues, (...) someone who supports you, so one doesn't feel lost. (...) As soon as control from hospital was gone and I was responsible myself, nothing worked out</i> (GE-SC:F29/affective disorder)
Longer inpatient stays and higher uncertainty of clinician at discharge	
C: <i>There is no sense of ownership of the patient. The community staff (...) do not have really motivation to facilitate the discharge because patient is risky in the community, so for them it's actually "he needs a little bit longer" etc. (...) Patients with personality disorders say "my community consultant said something completely different, he told me that I have a bipolar disorder..." and this can of course affect the treatment and length of stay, so there's difficulty with transferring the patients...</i> (UK-BT: psychiatrist)	P: <i>The problem is that a different clinician is in contact with me every time I stay at the hospital. It's a bit silly, because, no matter how much the clinician would like to get to know the patient, they won't be able. The patient would have to stay at the hospital half a year for that to happen</i> (PL-SC: F56/affective disorder)

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If you create all these interfaces you will obviously have more likely disengagement of the patients, ... there has been good research in many places and... the most single most powerful predictor if a patient will attend is if they've seen you before. ...all the other bits you can record, you can input telephone messages, letters—and all of this we do—but the single most powerful is this; that the patient has seen you before and has discussed the follow-up with you. And that's what I used to do... would give a date follow-up and then people would attend (UK-SC: psychiatrist).

Discussion

The international exploration of clinicians' and patients' positive and negative experiences with specialisation of care and personal continuity of care approaches has led to a comprehensive identification of number of features, which constitute the advantages and disadvantages of these different approaches. The study used a consistent methodology across five European countries: Belgium, Germany, Italy, Poland and the United Kingdom. It found commonalities in attitudes towards and experiences of patients and clinicians regarding specialisation and personal continuity of care approaches, which validates the results across borders. Many positive experiences of patients and clinicians with the personal continuity care approach not only relate to the high quality of therapeutic relationship based on trust and the sense of security, but also to the smooth transition between hospital and community care. Many positive experiences of patients and clinicians with the specialised care approach relate to concepts of autonomy and choice and to the higher adequacy of diagnosis and treatment. In addition to the experiences related to the quality of care discussed by both study groups, clinicians stressed also system aspects of providing mental health care: more effective management structure and higher professionalization of care within specialisation approach and the lower risk of disengagement from treatment and reduced need for coercion, restraint, forced medication or involuntary admission within personal continuity of care.

Strengths and limitations

This comparative qualitative study examines experiences of mental health professionals and patients regarding specialisation and personal continuity of care approaches in different European countries in a comprehensive manner, providing information with higher transferability than previous qualitative studies in this area. The data coding consistency has been checked across all countries. The research team was

multidisciplinary; therefore, the analysis and data interpretation benefited from different perspectives. Moreover, participants of that study received or provided care in countries in which different care approaches were encouraged by different funding mechanisms and political and clinical arrangements.

There are also limitations. While the participants were selected to achieve maximum variation sampling, the selection of interview participants was purposive. In addition, it included only those, whose mental and somatic health was good enough to carry out an in-depth interview. Therefore, we did not explore the opinions of patients who probably might have benefited less and have been less satisfied with the care received.

Results related to previous findings

Our results show that, despite the recent increase in specialised and technologically advanced medical treatments, neither clinicians nor patients have forgotten the importance of a more traditional part of medical practice: the relationship between clinicians and patients [16]. Therefore, it is not surprising that many positive experiences with the personal continuity care approach relate to the features of that approach, which increases the quality of the therapeutic relationship (a better therapeutic alliance; greater sense of security in crisis; less frustrating and less confusing delivery of care). For those reasons, many patients from the specialisation care participating in our study also declared preferences for having the same clinician—at least within one setting, but also across different settings. Those findings are supported by earlier research which suggests that trust is important to patients and continuity of care is a frequent theme in building trust. Moreover, trust in clinician–patient relationship often translates into trust towards the mental health care system in general [16–18].

Some positive experiences with the specialisation care relate to concepts of autonomy and choice (i.e. more freedom to choose the clinician; separation of a crisis period from a regular life). However, we argue that specialisation care offers more autonomy than personal continuity of care rather from an economic than from a philosophical point of view. While philosophical and ethical arguments underpin the idea for more patient choice, the economic arguments focus on patients having more choice between several clinicians or wards competing to deliver a service for them. However, it does not necessarily offer greater autonomy for the patient in their individualised treatment plan, as none of the clinicians may offer participation in decision-making [16]. Moreover, studies show that even if patients expect shared decision-making, they do not necessarily demand a fully autonomous choice [16, 19–21]. Calsyn et al. [22] suggested that choice may improve outcomes in patients who

are functioning relatively well, but not in patients with more pervasive and severe mental illnesses [16].

Our results point out two important advantages of the specialisation approach: higher adequacy (different clinicians provide new, additional information and more adequate diagnosis and treatment) and higher professionalization of care. It has been argued that increasing specialisation of services is inevitable as our evidence base expands, providing us with a better and deeper understanding of what exactly works best and for whom [9]. The arguments are forwarded in favour of a specialisation of care which emphasise the increase in the overall skills of the consultants carrying out their respective jobs in more focused manner and having sufficient time to participate in teaching, management and other non-clinical work [23].

The specialisation approach has been criticised as emphasising the biological aspects of illness over the psychological and social factors. A holistic view tends to be avoided, as it is easier to measure reductionist models of human experience and therefore establish a clear evidence base [16, 24]. At the same time, positive experiences related to the personal continuity care are more holistic care, a higher adherence to treatment, lower risk for disengagement from treatment and smooth transition between hospital and community care. It is another important argument in prevention of the appearance of the “Bermuda triangle” in mental health care system where lack of holistic view of patient needs and poor coordination of different providers’ tasks leads to the high risk of disengagement from treatment [1, 25]. Lack of personal continuity increases the need of the patients to look after the continuity of care themselves, and to see that relevant information is conveyed to different actors. Therefore, overall quality of care depends not only on the effectiveness of each agency, but also on the personal competence of patients [26–28]. Moreover, treatment of severely marginalised patients may require not only the personal continuity of care, but collaboration between clinicians and other professionals involved in delivery of medical and social care, covering a wide variety of physical, mental health, and social care interventions [1, 26–29].

That brings us to the issue of overall care organisation, as positive experiences with personal continuity care in our study suggest that this approach leads to shorter hospital stays as clinicians are able to react quickly to an emerging crisis and are more confident about treatment decisions. This approach is also more satisfactory for clinicians (seeing patient’s condition improved after discharge; fewer disagreements between different clinicians/services). In comparison, the advantages of specialisation of care suggest higher availability of staff in the hospital ward and more effective management structures. This might result in diminished workload and more efficient management of specialised hospital wards.

Conclusions

Our data lend support to both, personal continuity and specialisation of care—or when expressed differently, show shortcomings of both care approaches. Advantages as much as disadvantages of both approaches may balance or counterweight each other resulting in similar primary outcomes in the quantitative follow-up, as specific aspects of care may have different relevance in specific contexts and logistic and organisational considerations may favour one approach over the other. Therefore, even though there appears to be no quantitative differences in primary outcomes between personal continuity and specialisation of care [12], the issue remains important for many clinicians and patients and influences their experiences.

In our study, regardless of the form of care, there were patients who stressed that they received help they needed and who were very satisfied with medications they were prescribed. Many patients in both approaches to care reported feeling safe, respected, and confident to negotiate their own opinion regarding the course of treatment. Consequently, patients might link the positive experience of care, not to any specific approach, but to the high quality of care received within that approach.

Our qualitative study is of unique value by complementing the quantitative exploration where no significant differences between PCC and SC were found in terms of patient outcomes over a 1-year period [12]. It identifies and highlights substantial differences in terms of perceived advantages and shortcomings of both approaches. Therefore, along with continuous efforts to improve the quality of care, offering clinicians and patients a choice between alternative approaches needs to be considered, whenever possible and feasible.

Acknowledgements The authors would like to acknowledge the support of the funders, participants and wider COFI study group.

Funding This study was funded by the European Commission 7th Framework Programme (Grant agreement number 602645) and co-financed by Polish Ministry of Science and Higher Education (agreement number 3153/7.PR/2014/2 to conduct a co-financed international project no. W112/7.PR/2014).

Compliance with ethical standards

Conflict of interest The authors declare that they have no competing interests.

Ethical approval The authors confirm that the study had been approved by the appropriate ethics committees in all five countries and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

Ethical standards The authors confirm that the ethical approval was obtained in all countries:


1. Belgium: Comité d'Ethique hospital of acultaire des Cliniques St-Luc;
2. England: NRES Committee North East - Newcastle & North Tyneside;
3. Germany: Ethical Board, Technische Universität Dresden;
4. Italy: Comitati Etici per la sperimentazione clinica (CESC) delle provincie di Verona, Rovigo, Vicenza, Treviso, Padova;
5. Poland: Komisja Bioetyczna przy Instytucie Psychiatrii i Neurologii w Warszawie.

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